The Role of Government in Combatting Urban Health Problems

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One of the most pressing concerns in America today is health care. Around the country, people are debating the role that government should play in paying for and delivering health services, and how to best ensure public health. New York City is involved in that debate. We are thinking about how to organize health-care delivery so that the system offers everyone the chance for better health, and much as we are trying to do with public safety, to give people more security.

We know that we have the resources in New York City to offer better health care than we have been doing. We have the providers. The people providing health services in New York City are among the best and most respected in the country. We have the facilities. Our research and teaching institutions are the best in the world. We also have the commitment: New York City has a proud and unrivaled tradition of protecting the public's health.

That tradition deserves reflection, because I believe that all progress takes place by a solid understanding of how you got there, what your tradition is, and what your background is.

New York City was the first municipality to provide health care to the poor, when it started infirmaries in the tenements in the early part of the nineteenth century. New York City was also a pioneer when it created the nation's first Board of Health in 1866 to monitor and contain disease. As the largest city in the nation and the port of entry for immigrants from every corner of the globe, New York City faced public health issues that eclipsed, in multitude and magnitude, the experience of any other city in the United States, probably any other city in the world. We have been pioneers in both the science and practice of delivering compassionate care to the sick and infirm.

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Problems in Delivering Health Care

If we have the people, the expertise, the facilities, and the commitment, we should have the best health-care system in the United States. We do not. The problem is not the people, but the organization of services we have in the city. We need to evaluate how to allocate scarce health-care dollars in New York City, and how to determine the proper role of government, so that it can be helpful rather than harmful in the delivery of health-care services. As part of this determination, we certainly need to cut the tremendous bureaucracy that exists, and gets in the way of the ability to deliver health-care services to the patients who need them. This is a process of self-examination that requires confidence, not fear. Other urban centers are going through the same process with the same kind of fiscal pressures. New York is not alone.

Government should hold providers accountable and bring common sense to the delivery of health-care services. Government can accomplish that role. Tuberculosis, for example, which we once thought obsolete, resurfaced in the early 1990s in drug-resistant strains. At that time, New York City did not have the public health infrastructure to respond effectively, but it was able to do so over a period of 2 to 4 years. The city, through the Department of Health, developed the ability to deal with that public health problem. The process demonstrated the way in which a health-care system can function, if it is allowed to do its job, and if proper focus is placed on what the job should be. In the last 2 years, TB rates have declined significantly, because services have been improved, and we have been better able to confront the problem.

All such situations require a common-sense approach to health care that includes preventing disease and bringing health care into the community. As a city, we need to take the same common-sense approach, and an analysis of what the proper role of government should be in the delivery of health-care services. I think that means we need to stop weighting our health-care commitments only towards acute care.

New York City's system was built a long time ago, when things

were different. New York wanted to provide health care to everyone, and did so through a public hospital system that, at the time, made sense, and was the compassionate thing to do. So, New York City built what I consider to be a muscle-bound, gigantic system to try to deal with the problems of health care in the earlier part of the century. That was before Medicare and Medicaid, before, even, private insurance. It was before many of the systems that exist today to care for people who are poor. The remnant of that system remains, and we, so far, have not had the political wisdom or strength to deal with it, and conform it to the needs of people who live in New York today.

The statistics tell a sad story. The infant mortality rate in central Harlem is 83% higher than the national rate. The incidence of low-birth-weight babies in Harlem and Mott Haven was 114% higher than the national average. We could review any number of statistics like that in certain areas of New York City, which has the largest health-care system in the United States, the greatest talent and expertise, and devotes, by far, the most money to health care. For a population of 7 million to 8 million people, New York City spends about the same amount of money on Medicaid as does the entire State of California for a population of 33 million.

So, this is not about lack of talent. It is not about lack of resources. It is not about lack of money. We are spending more money than any other place in the country. The issue is an unwillingness to look at a system that is not serving us properly, and to make common-sense reforms and changes in the system. Inertia is controlling the situation. It is time to talk about other ways to deal with the problem.

A Paradigm for Reorganizing Health Care

One way to reorganize the health care system is to transit to Medicaid managed care, which is a vehicle for building primary-care capacity in underserved neighborhoods. It is important that, even with the difficulties with managed care and some of the problems in trying to access it, we continue to work with it, to

make it work, and to improve it. New York City will mandate, through the contracting process, that the managed-care plans that serve New Yorkers do what is best for the city and for its people, to help bring ongoing, preventive health care to the neighborhoods that need it most.

It is difficult to understand how it happened that New York City, for all its compassion, all of its commitment, and all of the resources it devotes to health care, had the unfortunate results that it has today. When I look at the problems in the city, whether health care, or education, and I see a city spending the kind of money that we spend, $8 billion for education, $8 billion to $10 billion for just the Medicaid part of public health, I say, this is a challenge to our decency and our intelligence to be able to do a better job. Nobody should believe that what we are doing is right. It is not. We can do better.

The creation of the federal Medicaid and Medicare programs, along with New York State's bad debt and charity-care pool, and the expansion of private insurance coverage create a different situation than the one that existed when we put this system together in the first place. Hitherto, we have not analyzed the difference.

In the current health-care environment, New York City's $4-billion hospital system, HHC, with its 11 hospitals, is an anachronism, and is illogical in light of what is going on and all of the changes that have taken place. Dr. Jeremiah Barondess, who was appointed by Mayor Dinkins to head another commission to examine HHC, recently told the City Council that the HHC system is "dysfunctional" and is likely to become more so as competition for Medicaid patients pits the system against voluntary hospitals.

The system once served a purpose. It was needed to provide care to the poor and the indigent, but today people have many more options for health care, and only 5.4% of HHC hospital discharges are indigents. The rationale for the system, now, only exists for these 5.4% of the people.

HHC has always been, and will continue to be, plagued by restraints and inefficiencies, because government does not run a

hospital system well, not in New York City, not anywhere. Waiting times for appointments can be three and four times longer than at voluntary hospitals. Medical-record clerks spend hours plowing through charts, some more than a decade old, to find the latest record on a patient, because the technology levels are not what they should be. These kinds of inefficiencies can compromise patient care even as they waste precious dollars, which do not come easily any longer, and are not going to come easier next year, or the year after.

We have to live in the real world. In that world, we have a state with a $5-billion deficit. It is in our interest to cut that deficit. Otherwise, the economy of this state will be finished. We have a federal government with an unbalanced budget. That means that anyone making realistic and sensible plans for the future has to plan for a contraction of money. I think we have to look at other ways in which we can deal with this system.

The patients, who once sought care at HHC hospitals out of necessity, are now telling us their preferences. They are choosing voluntary hospitals. Of the 86,000 new Medicaid admissions between 1989 and 1992, 92% were at voluntary hospitals; only 3% of Medicaid recipients chose to go to HHC hospitals. It is estimated that New York City will have more than 10,000 excess hospital beds in the next 5 years. If we stand by and we do nothing, it is undeniable that HHC facilities will be among the most vulnerable to the winds of change, because, as the number of beds contracts, the selection will be more and more for the voluntary hospitals by those who have the ability to select; that is, people who have Medicaid or some other form of insurance.

It is time to establish priorities and make some proactive decisions about health-care delivery.

An Argument for Privatization

New York City's investment in the costly, and now overbuilt, acute-care hospital system has not only drained resources, it leaves the city vulnerable to the rising public health challenges that must

be faced in the next several years. That is why we are pursuing the initiative of privatization. We are doing it with three hospitals, Queens Hospital, Elmhurst Hospital, and Coney Island Hospital.

Privatization allows New York City to step back and assume the role of "payer" and "monitor". There is a wonderful book called *Reinventing Government*, by David Osborn, that says that government best plays the role of steerer, not rower, of the boat. When government tries to do too much, it does it poorly. In New York City's case, by trying to own and operate eleven hospitals, the city government, to a very large extent, reduces its ability to play the role of monitor and regulator in the appropriate sense, even provider of resources to the voluntary, not-for-profit institutions.

Now, when it is not necessary for New York City to own and operate hospitals, it is irrational to continue to do so. It may have been necessary when people did not have insurance, Medicaid, Medicare, or other ways of providing for health-care services, but now we have a public system competing with a voluntary system for no reason other than the 5.4% of admissions who are indigent. Far better to cover them through contract than to try to continue this system that no longer works, because it has become something other than a health-care system. It has become, to some, a politically mandated jobs program. When I first talked about privatization, some political leaders in this city asked me, "What are you going to do about the jobs?" Not, What are you going to do about health care for the people who are going into these institutions?

New York City can deal with that, however. We can deal with it as we have dealt with the reduction of 17,000 to 18,000 workers in the city's work force: through severance programs and transitional programs, and by negotiating attempts to place some, if not all, of the workers. That is a different problem, however, than trying to add that to the already difficult problems of delivering health-care services. The issues must be separated, or the situation will go from bad to worse in the future.

Privatization also will help us improve the hospitals and the health-care system as a whole. We will be able to move government into the role that it performs best. If one could restructure

health care ideally in New York City (I realize that this cannot be done completely, but it should be the goal), one would want government to act as an honest and good-faith regulator of hospitals so that they deliver quality health care; to ensure that hospitals that have contracted with New York City carry out their contractual commitments; and to ensure that the hospitals fulfill a legal commitment to care for people who do not have coverage.

New York City would best be able to perform its role through the Department of Health. It may even be able to expand that role to deal with public health and to deal with the public health issues that we presently have; these issues are considerable, are the greatest in the country, and surely are going to emerge as even more important in the future.

These are the things that make sense. These are things that government can actually do. These are the things that fit into the natural role of government in the United States.

Privatization also allows New York City to be free of situations that not only hurt the city's budget, they also hurt the ability of New York to compete with other cities. For example: if, magically, one could re-create the entire present system and replace it with a private, voluntary system with which the city contracts to care for people who are indigent and contracts at a level that might involve much the same budgetary expenditures for the bad debt and charity pool, maybe even more, and continues to pay its portion of Medicaid, which is enormous; if New York City just accomplished that, it would save hundreds of millions of dollars each year in legal judgments and fees that New York has to pay now because the city owns and operates so many hospitals. There is approximately a one in four or one in five chance that if someone sues for malpractice in New York City, that person is, in effect, suing the City of New York, because we are involved in one of every four or five cases.

That is not the case in any other city in America because other cities— Los Angeles, Chicago, Miami—do not own 11 acute-care hospitals and a number of long-term-care hospitals. That is an enormous expense to New York City that does not have to exist

and that could become part of the contractual process. It is an expense that could otherwise be used to improve health care and to improve public health through the Department of Health, and that could be used for other purposes, such as educating young people better and more effectively.

So, there are many reasons why this has to be done. The final reason that privatization must come is that, if this reorganization does not take place and this re-emphasis in health care does not occur in New York City, something else will happen. There will be a major revision of the delivery of health care in the United States. I don't know the exact form of it, nor do President Clinton, Bob Dole, Newt Gingrich, or anyone else. They will fight about it, but they do not know what the final answer is going to be. Whatever the final answer is, however, it will involved additional coverage for people, perhaps something approaching universal coverage.

Much of that, no matter how effective my efforts, the governor's efforts, or the efforts of New York's Congressional delegation, Republican and Democratic, no matter how strong those efforts are, no matter how successful they are, some of that added coverage will be funded out of New York City by reducing the amount of money that comes to the City of New York. That will happen because New York City overspends, and so does the State of New York. We are also underfunded, but for a different reason.

If national leaders are trying to decide how to cover additional people, they are going to consider a state like New York and say, "We cannot continue a situation like that in the State of New York, which spends more on Medicaid than California and Texas combined. That cannot be permitted; a readjustment must be made." No matter how well we fight the political battle, something dramatic is going to happen. So, we had better restructure ourselves first, to absorb the coming transition. Part of that restructuring is to reduce dramatically the HHC bureaucratic structure. It is unnecessary; it adds tremendous expense; it adds a layer of irrelevant concerns, such as jobs programs, and political concerns, none of which would be the case if New York City were contract-

ing with voluntary, not-for-profit institutions; and in the long run it delivers poorer-quality care for people, by and large.

That is the system that we are in the process of trying to transform. We will continue to do that, and I think it useful to explain the reasons for it.

Fidelity to an Established Tradition

New York City's attempt at restructuring is not an attempt to step back from decisions that were made over a period of time, starting over a century ago and continuing through the early part of this century. New York City has always attempted to provide universal health care. It may have done it effectively sometimes, it may have done it ineffectively at other times, but that has always been a commitment of this city. In New York City, those deserving universal health care have always included people who are immigrants and people who are in the category of undocumented aliens. A good city, a decent city, will provide that. A city that has some sense of its own self-interest in terms of health will also provide it because a virus does not distinguish between an undocumented immigrant, an illegal immigrant, a legal immigrant, and a citizen. A virus affects anyone and can be transmitted from one to anyone else. A decent city also does not allow people on its streets to suffer from disease when it can deal with that and has the capacity to deal with it.

New York City will remain a city that provides care to people who are indigent. We will remain a city that provides care to the people who are here and who are indigent, without analyzing precisely their legal status. That will remain true in spite of the tremendous movement in the direction of Proposition 187 in the United States Congress. That movement is a terrible mistake, a mistake that I believe we are not going to make because America has gone through this sort of anger at immigrants and immigration before. Ultimately, Americans recognize the fact that there is something very special about us, particularly about New York City and people who come to it.

We need immigration. We need it to revive ourselves and to renew ourselves. We need thousands and thousands of people coming to this city every week, every month, who want to do better, because their coming here makes us do better. That is the reason that New York City is special, the best-known city in the world, and, I always like to say the capital of the world. I've said this to President Clinton, I've said it to Governor Cuomo, I've said it to Governor Pataki. Sometimes they look at me a little quizzically when I say it. But I now have won the battle, because when the Pope came here, the Pope said we are the capital of the world. Now when they dispute it, I will tell them to go argue with the Pope, and with an election coming up, let's see if they do that.

These are the directions that we are trying to set for health care in New York City. Our effort is intended to deal compassionately, realistically, and sensibly with the things that are happening around us. I ask that our ideas be considered, understood better, because they are intended to try to make this city one that not only lives up to its historic commitment to caring for people who are indigent, but also can realistically do that ten and 15 and 20 years from now. If we remain inert, we are headed for a disaster for everyone.